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ABSTRACT

Areas of agreement/conflict between academic medical centers and investor owned corporations are considered. Academic medical centers are part of the university system, which is responsible for education, research, and the related public good (e.g., nurturing of professions). Major areas for a potential confluence of interest between the academic medical center and an investor owned entity are: desire for efficient and effective management, desire for operating surpluses, need for capital to sustain the most modern technology, desire for quality image to the public, interest in highly educated and trained professionals, and commitment to continuing education. There are also six major areas that pose potential or real conflict between the two: purpose for new knowledge acquisition, responsibility for nurturing professions, business ethics versus professional ethics, time lines for key accomplishments, accountabilities, and standards and values. The differences are most sharply divided on the mission, goals, objectives, values, and professional ethics and standards. A complementary relationship can most easily be achieved with discrete joint ventures, commonly involving capital intensive high technology, ambulatory care, sophisticated research, and very little teaching. (SW)

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HOW WILL THE CORPORATIZATION OF HEALTH CARE INFLUENCE HEALTH PROFESSIONS EDUCATION

"The Effects of Corporatization on Academic Medical Centers"

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The basis for my comments on this subject come from my experience of twenty-five years in academic medical centers and the last three years in an Investor Owned Health Care Corporation. In these latter three years we have been involved in searching for ways to bring together the Investor Owned Corporation and Academic Medical Centers. I have viewed this effort as an experiment. In this regard, we have learned a great deal in a short time concerning what areas between these two entities are compatible and which areas are incompatible and potentially in conflict. Of these latter it is important to note those interfaces of some certainty of conflict and those areas that compromise provides a rational relationship.

During this period we have had operating experience with investor ownership of a variety of academic entities ranging from the full service primary teaching hospital and clinics of a medical school to specialty hospitals, HMOs, and specialized high technology free-standing ambulatory centers. This variety has provided an excellent basis to learn which entities work well and which do not and why, involving education, research and clinical care.

It is important first to recognize certain key attributes of the University Academic Medical Center and then to see which of these attributes provide a basis for a confluence of interest with the Investor/Owned entity and which attributes pose a real or potential conflict.

Academic Medical Centers are part of the American university system, a system that embodies a responsibility for education, research and related public good. There are many devices that the University employs to express its responsibility for the "related public good", as for example, the nurturing of professions.

Spinning out of the triad of research, education and related public good, there are at least six major areas for a potential confluence of interest between the Academic Medical Center and an Investor Owned entity. These include:

- A. Desire for efficient and effective management.
- B. Desire for operating surpluses.
- C. Need for capital to sustain the most modern technology.
- D. Desire for quality image to the public.
- E. Interest in highly educated and well trained professionals
- F. Commitment to continuing education.

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At the same time there are six major areas which pose potential or real conflict of serious proportion between the University and Investor/Owned entity. These are:

- A. Purpose for new knowledge acquisition.
- B. Responsibility for nurturing professions.
- C. Business ethics vs. professional ethics.
- D. Time-lines for key accomplishments.
- E. Accountabilities.
- F. Standards and values.

Looking first at the areas of agreement, the six I have cited are rather self evident. Both Universities and Investor/Owned entities recognize the critical importance of sound, efficient and effective management. Both have sometimes shown paradoxical behavior in this area. A university may have within it an outstanding School of Business, while the university management itself may be suboptimal. Investor/Owned entities which have good management as their hallmark, have at times demonstrated careless management in the health field, e.g., during the pre-DRG period of virtually unchallenged reimbursement by third party payors.

Nevertheless, sound management principles and practices are basic whether the entity is a not-for-profit university or an Investor/Owned Corporation. If the two can come together to improve management the only issue is on goal agreement. If the basic goals can be agreed to by both parties, then this is a win-win area.

The second area of agreement is the desire for operating surpluses - which the Investor/Owned entity calls profit. Some not-for-profit university hospitals have a larger surplus after expenses than their for-profit counterparts. Further some universities have a number of for-profit subsidiaries that are highly successful by any business standard. Further, many universities have a stock portfolio, land, oil and real estate holdings that are the envy of many Fortune 500 corporations.

The line in the budgets of U.S. medical schools that has experienced the greatest growth over the past decade is income from faculty practice. In fact, medical service income now accounts for 30% of all medical school income, greater than research grants, state appropriations or tuition. It is the single largest line in the budget. The inevitable conflict between the usual academic ventures of teaching and research against income generating patient care is obvious.

Similarly, the university board and administration are more and more finding themselves in potentially compromising positions balancing the allocation of university resources for teaching and research against the potential commercial value for another for-profit subsidiary.

The only difference I have found between the interest of universities and Investor/Owned entities in this regard is in the public perception. University leaders are cautious about the amount of surplus only for public relations. Were it not for the fear of public reaction against private contributions or state appropriations, most university leaders would accept unlimited surpluses.

The third area of agreement is in the realm of capital acquisition. Clearly it is becoming more and more difficult for universities to acquire sufficient capital for expansion and replacement needs, particularly in the area of high technology. Competition for scarce capital among university schools and departments is increasing. Here the health fields pose very special problems. One cannot recruit and maintain superior faculty without the latest technology for their research and clinical practice. It simply makes good sense to use outside sources of capital, as from an agreement with an Investor/Owned entity, when a health care unit has the potential for recovering these costs through practice income. This, then, spares the university's intrinsic resources for capital expenditures in programs vital to the university's mission, but for which there is no alternative source for funding. As with the issue of improved management, the only problem to be resolved between the university and the Investor/Owned entity regarding capital investment is that of goal agreement.

The fourth major area of agreement is that of a desire to have a public image reflecting the highest quality standards in whatever activities are undertaken. Clearly, this is a goal of every university. Investor/Owned entities have learned that this is important to the public for commercial activities. One only needs to watch a few hours of television advertising to see that the ads focus on product quality - not cheapness of price. How quality is measured for either the university program or the commercial service or product is an open issue. The point is, neither entity disagrees with the virtue. Whenever a joint venture can be structured that bodes a high quality image, both parties are in immediate agreement.

The fifth area of common agreement is in the high quality education and training of health professionals. The motives are different, but the endpoint is one of agreement. As described above, the university is dedicated to quality. It is judged by the quality of its products - the faculty, their research, and their graduates. To graduate students and postgraduate trainees of less than high quality is to fail by university standards. The Investor/Owned entities have learned that highly qualified professionals are good business. Providing the best service attracts business. Doing a service right the first time saves money in not having to do it over. Mistakes cost money in litigation beyond the cost of remedy. It is almost that simple. High quality in health professionals is good business.

There is a conflict regarding the educational mission of the university and the needs of the Investor/Owned entity. The Investor/Owned entities believe it is the responsibility of the university to prepare graduates in the detailed elements of practice in the latest commercial mode of health care delivery. For example, how to practice cost efficient medicine in an HMO setting. Universities, as will be discussed later, do not see their mission as preparing graduates for some immediate job placement.

The common ground on this argument is the final major area of agreement, that is, a commitment to continuing education. Even the best graduates and trainees would not remain at the cutting edge of their profession if they did not continue their education. Thus it is important to the Investor/Owned entity to sustain quality, if quality is recognized to be important. To the University, continuing education is gradually being accepted as a part of the continuum of education for professions. It has not been an easy task to bring this acceptance to the University. While not a primary motivator, universities have, nevertheless, filled part of the gap from falling enrollment of undergraduates through continuing education programs for older adults.

The Investor/Owned entity has further interests. New skills, techniques and procedures reflect marketing opportunities. But these opportunities are only as good as the professionals who have been taught these new skills, techniques and procedures.

In addition, the Investor/Owned entity would like to have continuing education bring the health practitioners into the latest commercial mode of practice, as in HMOs, to learn how to manage reimbursement policies to the benefit of business, etc..

Universities may accept continuing education in the science of medicine as a university function, but many do not accept the role in the business of medicine.

Now let us look at the six major areas of real or potential conflict. The first concerns the purpose for research and education. The university faculty considers what is known, searches for new knowledge and passes all of this along to the next generation. The basic motive is truly the love of knowledge and the never ending search for truth.

Practicality dictates in our modern times that professors must eat and have shelter, thus they are indeed paid a salary. Few would ever suggest that there is an equivalence of pay for the effort invested. What is most important, however, is that pay, income, or profit is never the primary driving force for these professorial efforts.

Further, the true purpose of a university education is not and should not be to train graduates for an occupation. Rather, a university first prepares their students for life - a life that is broader, fuller, and part of the greater culture of mankind than would be otherwise. Concerning an area of professional specialization in a university, such as medicine, or nuclear physics or law, the major thrust is to prepare the graduate to be a lifetime student of that field, not to leave the university with all he will ever know.

By comparison, every major business, also, desires new knowledge in its field, but for a purpose different from the University. Business wants the new knowledge to be a leader and continue to command market share and profits. The Investor/Owned entity has no place for education and research for non-remunerative rewards. In contrast, Universities desire new knowledge for the sake of new knowledge whether there is ever a profitable application. In fact, if all research were business oriented, the knowledge base of our society would be woefully limited.

It is recognized, however, that research knowledge obtained for only the sake of research knowledge, often later proves to have significant commercial value originally never considered. Examples are endless. Flemming did not study the mold that was killing his bacteria for the purpose of a commercially exploitable antibiotic. Nor for that matter did Waxman classify numerous soil bacteria so he could some day go back and find the product of one - streptomycin - to attack the tubercle bacillus.

Or what of the commercial value of recombinant DNA following the mass of basic genetic and biochemical research. Or more recently, the brilliant work of Candace Pert at the National Institutes of Mental Health. There, over the past fifteen years, she and her colleagues have studied peptides and peptide receptors and mapped receptor patterns in the brain. Many must have felt this to be hopeless academic trivia. Now it appears to be the basis for a potentially major breakthrough in the treatment of AIDS.(1)

The danger in these examples is falling into the trap of believing that all basic knowledge must have a practical, business value someday. It doesn't. The fact still remains, without the basic knowledge collected for knowledge sake, we would have failed to have the many wonderful business ventures of today for business never has nor never will be able identify and fund all the basic research needed for itself. It will always rely on the vast reservoir developed through academia. Were it not so, business would still be studying more efficient use of whale oil for illumination.

But, in all candor, if research and education cannot be seen to be beneficial sooner or later to the bottom line, to business it is an anathema.

The second major area of conflict focuses on the role that the Academic Medical Center should play in nurturing professions. Concerning any profession, sociologists have defined certain attributes that distinguish a profession from business or other occupations. Paul Starr has summarized these attributes as follows: "A profession is an occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics." (2)

Thus the legitimization of professional authority involves these three claims: first that knowledge and competence of the professional has been validated by a recognized group of peers; second, that the consensually validated knowledge and competence rest on rational scientific grounds; and third, that the professional's judgement and advice are oriented toward a set of substantive values, such as health. (3)

Universities have been in the forefront in nurturing the development and growth of professions. They provide the repository of the knowledge set. They test and verify the validity of the knowledge. The faculty of the field often are the major peer group to judge professional competence. The universities attempt to set the ethical standards with the students.

Investor/Owned entities have no responsibility parallel to that of the university in the nurturing of professions. One of the derivatives of being a profession is having a code of ethics. It is this set of professional ethical values that represents the third major area of conflict, viz., the difference between professional ethics and business ethics. It has often been suggested that these elements of medicine, or even the health professions more broadly, are more self serving than truly professional attributes. It has also been suggested that while the practice of medicine may be a profession, operating a hospital is a business.

The professional umbrella over both the hospital and the health professions practitioners can be seen in sharp relief in the statement of "Ethical Principles in Health Care" for hospital ethics committees as iterated by the American Hospital Association. (4) They include: patient autonomy, beneficence, nonmaleficence, justice, truth telling and promise keeping. To what extent are these ever applied as primary business ethics?

Of course there is a significant overlap between business ethics and professional ethics, but it is not one hundred percent. Can you imagine the admonition of caveat emptor - let the buyer beware - placed above the entrance of a hospital or a physician's office? Truth telling clearly belongs in business because it is good business. But, failure to tell the whole truth may be winked at in certain business, but is unacceptable in medicine.

This is not to say that businesses are unethical. It is rather an acknowledgment that the ethical issues and standards of a business and a health profession have differences. And, these differences can create a conflict.

The fourth major difference that can produce conflict is the different time line that each entity follows. For the corporation, particularly the publicly traded corporation, there is a fiscal report made to the share holders and to the public every ninety days. The value of knowledge learned from research and from knowledge taught is often years in being known to a university, if, in some cases, ever. Between these two extremes is a chasm. The business entity needs and must have immediate profitable returns to report to the shareholders if it is to maintain itself. The program objectives of Academic Medical Centers rarely can be tracked in ninety day aliquots.

Another difference in the time lines is seen in the philosophy of mission. It is the mission of every university to be that repository of old knowledge, the search for new knowledge and the vehicle of transmission through the decades and even centuries. The oldest universities are now over a thousand years old. Whatever a university undertakes, it is usually with a view of the long term, of enduring values, and not of any short-term monetary profits. The publicly traded corporation that reports failing profits every ninety days soon finds itself in trouble, with stock holders, directors and raiders.

Corporations are here today and merged tomorrow - or was it this afternoon. The temporal nature of business with corporate takeovers, mergers, bankruptcies is now common lore. With these two different time-value sets, it is easy for representatives of each side to sit and totally talk past each other.

The fifth major area of conflict is that of differences in accountabilities. As just described, the Investor/Owned entity is accountable to the investors. Their interest is financial. If the value of the stock falls, there is little solace in the pride of investment. Universities have a pluralistic constituency. While legally a Board of Regents or Trustees may be responsible, there are many other groups to whom the university must be concerned. These include current students, alumni, faculty, state governments (even for many private schools), local communities etc. This is not to say that businesses do not have to worry about their customers, the community etc. Rather, it is the sharpness of accountability of the corporation to the shareholders and for narrow fiscal success that makes the major distinction.

It is easy to see this problem in an example. An Investor/Owned entity may be prepared to do a major project with a University having found that the project has a profitable outlook. The university may still have a long way to go before making a final decision, as it may need to involve discussions with any number of constituent groups and reach a positive consensus. This is so easily understood by those of us who know universities. In contrast a corporate executive can find it totally incomprehensible.

The final difference concerns standards and values. In simplest terms the standard by which an Investor/Owned entity is judged is in the value and the growth of value of the stock to the shareholders. Universities have a complex eclectic system for assessing worth. Both universities and corporations have oversight or accrediting bodies that require that certain public standards be met. These standards are quite different for each.

Of more significance is the peer standard over the academic medical centers, involving even more than the professional ethical values, that is virtually non-existent with a corporation.

In addition to the attributes of both the Investor/Owned entity and the University Academic Medical Center, there are changes in the environment of our society, the health professions, corporations and universities that influence the role of corporatization on health professions education.

First there is the corporatization of the practice of medicine itself. The fact that significant corporatization has occurred is well known.(5) There are new roles for health professionals and these roles are still changing. Perhaps most significantly is the change of the physician from being self-employed to being employed by some one else.

The physician and the patient are known as the first and second parties in health care. Insurance payors entered and are called the third party. Now, large employers have become the fourth party in health care.(6) They purchase the health care for their employees and more and more are dictating where and by whom it will be delivered. They are looking for cost efficient care and the providers are having to learn new ways of practicing medicine.

The story of the advance of HMO's is well known.(7) While it is argued as to how far and how fast HMO's will continue to advance, they are a reality and medicine is practiced somewhat differently there. There are still other forecasts of changes in the delivery of health care that are not agreed to by all of us. (6)

Regardless of the particular mode of delivery of care, especially if designed to save money rather than to improve outcome, what is the responsibility of the university academic medical center vs. the benefiting corporation for the special business training?

What have we found from experience regarding conflict in each of the areas cited above. First we have found ample examples of real conflict for each of the differences cited. In fact, we have found that there are interfaces between a corporation and an academic medical center that should probably always be avoided because the conflict is so inevitable. There are, however, other areas where complementary relationships can be achieved to the benefit of both parties - a true win-win circumstance. In between are areas in which mutually beneficial results may be achieved, but each party has to recognize that a compromise on both sides must be struck. Here, both parties must exercise great caution in what it is giving up versus what is being achieved. It requires, in fact, a very carefully structured agreement.(8)

The areas in which a true complementary relationship can most easily be achieved are the discrete joint ventures, commonly involving capital intensive high technology, ambulatory care, sophisticated, predictable research and very little teaching.

The areas that are most difficult to develop into a win-win for both parties are those involving the inpatient setting of variable, unpredictable clinical activity, and in which there is intensive teaching at the core of the curriculum or training program. Thus, in such a circumstance, even though the clinical volume may drop, and therefore the revenue, the need for the teaching activity remains high. Nevertheless, the reaction of management will be to curtail the staffing to match the decline in clinical activity. Staffing reductions on core units mean loss of key personnel skilled in teaching, often skilled in research protocols, and cannot simply be furloughed and brought back each time the clinical needs go up or down.

Similarly, the number of residents supported by the hospital is determined by several factors. One factor is the clinical load. Most residency programs are a minimum of three years. It is not possible to juggle the number of residents for short term variances in the patient census. This is but one more example of the problems stemming from differences in time lines of corporations and academic medical centers.

Let us take pediatrics as an example. With the average number of patients on the pediatric service it may justify the training of ten residents in each of three years. This justification is both for educational purposes and for income to the hospital to pay the cost of resident education. If the number of pediatric patients drops below a critical level, the hospital may not have income to pay for resident education and achieve an adequate return on investment. While there is no way that residents in the midst of a three year program can be released, any academic medical center can shift the residents to other affiliated sites to protect their training, but the base hospital cannot recover lost revenue from the drop in patient census. This creates great tension.

Another example of tension occurs if the residency program director chooses to rotate residents through research labs or other activities which may truly enhance their training, but which provide the hospital with no clinical service that enhances income. In otherwords, the hospital's interest is in revenue from clinical activity. This may not always match the needs of the individual resident or the training program. Where it does not match, tension abounds.

A further example of conflict occurs if the corporation owning or operating the hospital views the training programs as a prime source for its own need for health professionals. This interface has two elements. The first concerns simple numbers. The second concerns the actual training content.

Universities have always been reluctant to structure the size and content of educational programs to fit the immediate commercial market for a given profession or occupation. The rationale, as discussed earlier, concerns the universities obligation to educate students for a lifetime of growth as individuals and in their profession - not the shortsighted goal of today's needs only. Further, a strictly commercial view for graduates could easily wipe out many graduate programs in the humanities and basic sciences. In otherwords, corporations have a need for individuals with specific competencies for today.

Universities are producing graduates for the next several generations. Thus, this and the other intrinsic conflicts require that any relationship between the university and a corporation be structured as a "wise agreement".(9) I use this term as it is used by Fisher and Urey in their book GETTING TO YES.(11) Such an agreement 1) meets the legitimate interests of each side to the maximum extent possible, 2) provides for the resolution of conflict fairly, 3) is durable and long lasting, and 4) takes community interest into account.

In summary, universities in general, and the health professions in particular, have significant differences from business corporations. These differences are most sharply divided on the mission, goals, objectives, values and professional ethics and standards.

In some activities, the potential for conflict from these differences is minimal and a sound relationship is feasible to the benefit of both parties.

In other types of relationships, the potential for serious and destructive conflict is so great, that one must question whether a "wise agreement" can be reached to serve and protect the interest of both parties.

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